

Comments for the Record
House Committee on Ways and Means
Subcommittee on Health
Hearing: 2011 Medicare Trustees Report

June 22, 2011, 9:30 AM

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Chairman Herger and Ranking Member Stark, thank you for the opportunity to submit my comments on this topic. The Trustees are quite correct in providing an alternative scenario, where they estimate the impact of what Congress is likely to do. In our opinion, they are still overly optimistic. The Center offers two scenarios to consider – one which relies on tax reform and a second which reforms how premiums and COLAs are calculated.

Option 1 – Tax Reform

While the trustees must offer their projections under law, the real story on what will happen cannot be determined. The entire debate on cost cutting is premature until the impact of pre-existing condition reforms on the market is known. The issue with the pre-existing condition reforms, which no one is talking about, is that the mandates under the *Affordable Care Act* (ACA) may be inadequate to keep people from dropping insurance - and will certainly not work if the mandate is rejected altogether (which is now Dogma in the GOP).

If people start dropping insurance until they get sick – which is rational given the weakness of mandates – then private health insurance will require a bailout into an effective single payer system. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions while repealing mandates and pre-existing condition reforms.

In the event that Congress does nothing and private sector health insurance is lost, the prospects for premium support to replace the current Medicare program is lost as well. Premium support also will not work if the ACA is repealed, since without the ACA, pre-existing condition protections and insurance exchanges eliminate the guarantee to seniors necessary for reform to succeed. Meanwhile, under a public option without pre-existing condition reforms, because seniors would be in the group of those who could not normally get insurance in the private market, the premium support solution would ultimately do nothing to fix Medicare's funding problem.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding).

The committee well understands the ins and outs of increasing the payroll tax, so I will confine my remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical. Unlike a VAT, and NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The Child Tax Credit should be made fully refundable and should be expanded to include revenue now collected under the dependent exemption, the home mortgage interest deduction and the property tax deduction. Transitioning these deductions will allow a \$500 per month per child distribution with payroll. It will likely increase incentives to expand affordable housing and may not decrease housing for the wealthy, who are less likely to forgo vacation housing or purchase of luxury housing for want of a tax cut, as the richest families likely pay the alternative minimum tax anyway, so that they do not fully use this tax benefit now.

This tax should fund services to families, including education at all levels, mental health care, disability benefits, Temporary Aid to Needy Families, Supplemental Nutrition Assistance, Medicare and Medicaid. If society acts compassionately to prisoners and shifts from punishment to treatment for mentally ill and addicted offenders, funding for these services would be from the NBRT rather than the VAT.

This tax could also be used to shift governmental spending from public agencies to private providers without any involvement by the government – especially if the several states adopted an identical tax structure. Either employers as donors or workers as recipients could designate that revenues that would otherwise be collected for public schools would instead fund the public or private school of their choice. Private mental health providers could be preferred on the same basis over public mental health institutions.

If cost savings under and NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired

elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Conceivably, NBRT offsets could exceed revenue. In this case, employers would receive a VAT credit.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets. Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

The Center calculates an NBRT rate of 27% before offsets for the Child Tax Credit and Health Insurance Exclusion, or 33% after the exclusions are included. This is a “balanced budget” rate. It could be set lower if the spending categories funded receive a supplement from income taxes.

If less radical reform is desired, the Committee should consider premium increases.

Option 2 – Premium and COLA Reform

Bruce Bartlett wrote in the New York Times Economix Blog on May 17 on the nature of the Medicare financial problem and how to fix it. The information he imparted is invaluable, however I disagree with his solution, which is to stop doing the Doc Fix. He relates that the ACA expansion of funding brought the Hospital Insurance Trust Fund (Part A) into balance, with parts B (doctor visits) and D (Drug coverage) responsible for most of the unsustainable cost growth, as patient premiums have declined from 50% of spending to 25% and with Drug coverage not at all close to covering program costs. (The CBPP states that premiums were always 25%, though if true, they are inadequate to control cost).

Stopping doctor bills from going up on the demand side will not work. We know that because it did not work for Medicaid - since restricting payments have stopped most doctors from taking Medicaid). This finding has a great deal of impact on what is possible in preventing the doctor fix.

The problem with Medicare Part B is that increases cannot keep up with costs, like they do in the private market, because doing so violates the commitment to not cut Social Security benefit checks. The cost of living adjustment must be high enough to cover the premium increase each year - although for many that is all it does. Further cuts bring up the specter of seniors eating cat food to make ends meet, hence the reason that the Fiscal Commission was called the Cat Food Commission by progressives.

Premium support and not patching doctor fees are attempts to make doctors restrict their costs - both to seniors and overall. Prices naturally rise more quickly than inflation because these services are subsidized, so any co-pay must be increased to slow demand from users in exactly the same way the market would without subsidies or insurance. The desire to make doctors pay more is a recognition that the main impact of both insurance and subsidies (and subsidies for insurance) is

higher income for doctors and a larger medical care sector than would otherwise occur in a free market.

Our hybrid system is the most expensive option - either going to much less comprehensive insurance for everyone or an entirely governmental system would be cheaper, but is politically untenable (at least until private insurance collapses or is eventually supplanted by an ever expanding public option).

Going after doctors still won't work, however, as the Medicaid experience clearly shows. Premium support is a way to have insurance companies go after doctors instead, but that will likely yield the same result. Shifting the financial obligation to employers and past employers as part of a Net Business Receipts Tax would likely control doctor fees, although such a proposal will face resistance from both the medical and insurance sectors, even though it is the most likely to save money. Even if such a program is adopted, some employers are too small to support a medical staff or support retiree health care, so some kind of public program is still necessary, with reform all the more crucial.

Making patients more conscious of their care might do the trick, both with more realistic premiums for Part B and Part D, with both rising to absorb half the cost - although premiums could be lowered by increasing co-pays and providing seniors with Flexible Spending and/or health savings accounts. The problem is that this is untenable when dealing with a population with largely fixed incomes. That problem, however, is not unsolvable.

The obvious solution, which no one has yet suggested, is to change how COLAs are calculated, moving from the wage index to an index based on what seniors actually buy - especially health care. If premiums were increased quickly, COLA changes would have to be as rapid.

Such a proposal would hasten the date that the Old Age and Survivors Insurance fund needs rescue. It also impacts lower income seniors to a greater extent than higher income seniors, since they have less left over after any mandatory co-pay. Either bend points would have to be reset or the entire complicated system of bend points would have to be replaced a new method of crediting contributions, where employer contributions are credited equally rather than as a match to the employee contribution - thus moving redistribution from the benefits side to the revenue side.

An average employer contribution would provide even more incentive for increasing the amount of income subject to benefits - or even eliminating the cap altogether. Of course, if you do the latter, we might as well simply use a Net Business Receipts Tax or a VAT to replace the employer contribution (which captures all income with the latter burdening imports as well)

Thank you for the opportunity to address the committee.

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